HOME HEALTH REPORT
State Form 51449 (7-03)
Indiana State Department of Health
410 IAC 17-10-1 (o)

I. IDENTIFICATION OF THE ORGANIZATION

Name of Agency	

Street Address	

City		State	

County		Person Completing Form	

II. SOURCE OF ADMISSION

REFERRAL SOURCE FROM	NUMBER OF PATIENTS
Self or Family	
Physician Referral	
Health Department	
Hospital (Inpatient or outpatient)	
Nursing Facility	
Other /Unknown	
Total Admissions and Carry Over	

III. DEMOGRAPHIC CHARACTERISTICS OF PATIENTS

AGE GROUPS	MALES	FEMALES
Under 1 Year Old		
1 to 4 Years		
5 to 14 Years		
15 to 24 Years		
25 to 44 Years		
45 to 64 Years		
65 to 74 Years		
75 to 84 Years		
85 Years and Older		
Total Patients By Gender		

IV. DIAGNOSTIC CHARACTERISTICS OF PATIENTS

PRIMARY DIAGNOSIS	NUMBER OF PATIENTS
Infections, Parasitic (001-041, 045-139)	
Acquired Immunodeficiency Syndrome (042-044)	
Neoplasms (140-239)	
Endocrine, Nutritional , Metabolic (240-279)	
Blood, Lymph, Spleen (280-289)	
Emotional, Mental (290-319)	
Nervous System, Sense Organs (320-389)	
Circulatory system (390-459)	
Respiratory system (460-519)	
Digestive System (520-579)	
Genitourinary System (580-629)	
Pregnancy, Puerperium (630-679)	
Skin, Subcutaneous Tissue (680-709)	
Musculoskeletal Connective (710-739)	
Congenital Anomalies (740-759)	
Perinatal (760-779)	
Symptoms, Ill Defined Conditions (780-799)	
Injuries, Poisoning, Violence (800-999)	

Other Medical with no ICD-9-CM Code	
All Patients	

V. GEOGRAPHIC DISTRIBUTION AND IDENTIFICATION OF NUMBER OF PATIENTS AND VISITS BY COUNTY

NAME OF COUNTY	NUMBER OF PATIENTS	NUMBER OF MEDICAL VISITS	NUMBER OF HOURS (OPTIONAL)
TOTAL			

VI. DISCHARGE DESTINATION

DISCHARGE DESTINATION	NUMBER OF DISCHARGES
To Hospital	
To Nursing Facility	
To Self or Family	
To Hospice	
To Other Agency for Continuing Care	
Patient Died	
Other (Refused Care, Moved, etc.)	
Total Discharges	

VII. ESTIMATE OF FUNCTIONAL REHABILITATION PROGNOSIS

LEVEL OF INDEPENDENCE	PERCENT ESTIMATE OF POTENTIAL
Percent of Patient with Good prognosis-for improvement	
Percent of Patients with minimum improvements expected	

VIII OVERALL CHANGE IN CARE NEEDS OF ALL PATIENTS

EXPECTED POTENTIAL FOR RECOVERY UPON ADMISSION	NUMBER OF PATIENTS
Good Recovery Potential	
Poor Recovery Potential	
Unknown or No Change Expected in Recovery	

VIII. SOURCE OF PAYMENT

THIRD PARTY PAYER	NUMBER OF PATIENTS
Medicare	
Medicaid	
Medicaid Waiver	
CHOICE	
Other Government (Local, state, federal)	
Private Health Insurance	
Health Maintenance Organizations	
Community Funds (i.e. contributions)	
Self Pay / Family Payment	
Uncompensated	
Other Payment Source	
Total from all Payers	

X.

COMMENTS